

Coordination of Care Treatment Plan

Welcome to the Behavioral Health Coordination of Care Treatment Plan. Access to the complete form will be granted upon completion of the Authorization Information section. Please Enter a valid IEHP ID, authorization number, select a Behavioral Health Service Provider and select a Request for Additional Services option.

* denotes a required field

Request Information

| | |
|-------------------------------------------|-------------------------------------|
| *IEHP ID: | <input type="text" value="IEHPID"/> |
| *Authorization Number | <input type="text"/> |
| *Requesting Provider | <input type="text" value=""/> |
| *Request For Additional Services | No Further Treatment Requested |
| Next Scheduled Visit Date (if applicable) | MM/DD/YYYY |

Member Information

| | | | |
|----------|---------|------------|-----------|
| Name: | Gender: | DOB: | Age: |
| Address: | City: | State-Zip: | Phone: |
| IEHP ID: | CIN: | MediCare: | Medi-Cal: |
| LOB: | County: | Aid Code: | Group: |

Member PCP Information

| | | | |
|----------|-------|------------|--------|
| Name: | ID: | NPI #: | Phone: |
| Address: | City: | State-Zip: | Fax #: |

Requesting Provider Information

| | | | |
|---------------|---------------------|------------|--------|
| Name: | ID: | NPI #: | Phone: |
| Address: | City: | State-Zip: | Fax #: |
| Request Date: | Provider Signature: | | |

Diagnosis

| | | | |
|----------------------------------------------|--------------------------------------------------------------|----------------------------------|----------------------------------|
| *Primary Diagnosis | <input type="text" value="Search Primary Diagnosis ICD"/> | <input type="button" value="x"/> | <input type="button" value="Q"/> |
| *Secondary Diagnosis | <input type="text" value="Search Secondary Diagnosis ICD"/> | <input type="button" value="x"/> | <input type="button" value="Q"/> |
| Additional Diagnosis | <input type="text" value="Search Additional Diagnosis ICD"/> | <input type="button" value="x"/> | <input type="button" value="Q"/> |
| Physical Disorders and/or Medical Conditions | <input type="text" value="Search Disorders/Conditions ICD"/> | <input type="button" value="x"/> | <input type="button" value="Q"/> |

Current Medication

*Is the Member currently taking mental health medication NOT listed below?

*Drug Name *Dosage Form *Strength (mg/ml) *Quantity

*Brand Name *Dosage Form *Strength (mg/ml) *Quantity

Add Medication +

Pharmacy Information (Past 6 Months)

| Drug Name | Prescriber | Filled By | Qty | Filled On |
|-----------|------------|-----------|-----|-----------|
|-----------|------------|-----------|-----|-----------|

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Unfilled Prescriptions (Past 1 Month)

No Records Found (1 month prior)

Visit Information

IEHP strongly encourages communication between treating specialists and referring Providers, to support coordination and integration of care efforts for our Members. Therefore, we request that a Release of Information be signed by our Member and included with this form, which will allow the information contained on this form to be shared securely with the designated provider through IEHP's Provider Portal.

Last Known Member Phone # (e.g. 9991234567):

*Verified Member signed the required Release of Information Form allowing IEHP to release medical and behavioral health information to PCP or Referring Provider.

Please attach completed Release of Information form in the Supporting Documents section below. [Click here to print the release.](#)

*Discussed referral with Member who is in agreement.

*Co Treating BH Provider Other Than Self:

*Have you addressed clinical concerns with other BH Providers for this Member?

*Have you been in communication with the Member's prescriber of psychotropic medication?

*Have you communicated medical concerns with Members primary care doctor(s)?

Note: Different expanded options for After Care Plan

After Care Plan (Select ONE from below)

- Provider Referred Stable Member Back to PCP for Ongoing Psychotropic Medication Management
- Provider Referred Member to Community Resources or Self Help Groups for Ongoing Support
- Member Discontinued Treatment (Please indicate why)**
 - Member Dropped Out**
 - Member Relocated
 - Member Expressed No Interest in Treatment
 - Other
- Provider Referred Member to Higher Level of Care
- Treatment Completed

After Care Plan (Select ONE from below)

- Provider Referred Stable Member Back to PCP for Ongoing Psychotropic Medication Management
- Provider Referred Member to Community Resources or Self Help Groups for Ongoing Support
- Member Discontinued Treatment (Please indicate why)
- Provider Referred Member to Higher Level of Care**
 - County Mental Health Program
 - Other**
- Treatment Completed

Additional Clinical Information

Special Instructions / Comments

Attach Supporting Documents

Up to 8 PDF or Word files, 10 MB per file maximum size

Note: Dragging and dropping files into browser window may navigate away from page

| Filename | Size | Status |
|------------------------------------------|------|--------|
| <input type="button" value="Add Files"/> | 0 b | 0% |

Submit

Cancel